

PATIENT NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_

**FINANCIAL INFORMATION**

**Monthly Income** (List source of monthly income BEFORE taxes and for ALL household members)

Income Source	Amount	Income Source	Amount
Wages/Salary of Client		Housing Assistance- Amount HUD Pays	
Wages/Salary of Husband/Wife		Social Security Income	
Wages/Salary of Partner		Disability Income	
Wages/Salary of Parent/Guardian		Other Income Pension/Veteran/Retirement	
General Assistance-or AFS/AFDC		Other Income Alimony/Child Support	
Worker's Compensation		Other Income Dividend/Interest Investment	
Unemployment		Other Source-Relationship to Client	
<b>Total Monthly Income</b>		<b>Total Monthly Income</b>	

Family Household Size: \_\_\_\_\_

**FINANCIAL AGREEMENT:** The undersigned SEVERALLY agree, whether signing as a patient or otherwise, that in consideration of the services rendered to patient of the account is guaranteed by the undersigned in accordance with the regular rates and terms of the center and other medical providers, and is payable to the center and other medical providers. While any insurance or other protection related to the account of the center and other medical providers may be hereby assigned to and payable directly to the center and other provides, the undersigned clearly understands that the obligation to pay the center and other medical providers is primarily on the patient and the undersigned, and while insurance received by the center and other medical providers will be applied to the patient's account, any part of the account not so paid by insurance is nevertheless owing and payable. In case of default of payment, and if these accounts should be placed in the hands of a Collector, or an Attorney for collection, all collection fees, attorney fees (which shall equal one-third of any balance due), cost and other expenses will be paid by the undersigned. Notice of dishonor, demand and protest are waived. It is further agreed that due to the high cost of billing and refunding small amounts, the center will not bill or refund underpayments or overpayments of less than five dollars (\$5) on final balances, except on a request of the patient or responsible party.

**PERMISSION TO RELEASE PATIENT INFORMATION**

Memphis Health Center (MHC) is hereby authorized to disclose all and/or any part of the patient's medical record to any person which is or may be liable for or responsible for payment of any of the charges of the center and/or medical providers, including but not limited to, insurance companies, medical or hospital services companies, worker's compensation carriers, employers and welfare funds. I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare or Medicaid/TennCare claim.

Patient at Memphis Health Center consents to disclosure of information for purposes of treatment, payment and health care operations. Patient may consent to receipt or disclosures of health care information for other purposes as well.

If you have a spouse, friend or relative that may call on your behalf to obtain appointment dates and time, test results, etc., we will not give that information out unless his/her name(s) is provided for our records. I hereby give permission to the MHC to allow receipt of the following to those listed below should he/she call or come in to inquire. Please check what you will allow to be released.

- Medical Test Results
- Medications
- Appointment Confirmation
- Other \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Relationship: \_\_\_\_\_

- I **do not** consent to information about me to be released to others, except as I have consented, or may in the future consent in other authorizations or consents provided to me by Memphis Health Center, or as required by law.

**The above conditions apply to all areas within the center and this form is valid at each site. The release of information set forth herein above is valid for one year from date of services, and the assignment of insurance benefits and financial agreement is valid and binding until final settlement of the account is received. Further, I agree that the terms of this agreement shall apply to all subsequent and future services rendered to me, my spouse, or my dependents by the center and other medical providers unless this agreement is revoked by written notice sent certified mail prior to the subsequent date of services.**

Patient's Signature (or Representative/Surrogate decision maker) for consent to treatment and release of information:

\_\_\_\_\_  
 Signature Date Time

Responsible Policyholder's Signature for Insurance Assignments:

(1) \_\_\_\_\_  
 (2) \_\_\_\_\_